Pediatric Health Partners, PLLC

Office Policy

Our goal is to provide and maintain a good provider-patient/family relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please ***read each section carefully*** and initial. If you have any questions, do not hesitate to ask a member of our staff.

Appointments

1) We value the time we have set aside to see and treat your child. We do not double book appointments. If you are not able to keep an appointment, we would appreciate 24-hour notice. There is a charge of $50 for missed appointments.

2) If you are late for your appointment (well visit >15 minutes; sick visit >7minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment to another provider or a different day.

3) We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.

4) Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered as a healthy (well-child) visit.

5) Non-emergency appointments such as physicals, well child exams, attention deficit/hyperactivity disorder checks, and similar visit types may be rescheduled if there are outstanding balances or if a co-payment is not made at the time of service.

Initial: _____

Insurance Plans

Please understand: Health insurance is a contract between *you, your employer*, and *your insurance company*. It is important for you to be an informed consumer who understands the specifications of your policy.

1) It is your responsibility to keep us updated with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement**.

2) If we are your primary care provider, make sure our name or phone number appears on your card. If your insurance company has not yet been informed that we are your primary care provider, you may be financially responsible for your current visit.

3) It is your responsibility to understand your benefit plan regarding, for instance, covered services and participating laboratories. For example:

a. Not all plans cover annual healthy (well) physicals, sports physicals, or hearing and vision screenings. If these are not covered, you will be responsible for payment.

b. For children younger than 2 years, there is a limit as to the number of allowable well visits per year. If the number of visits is exceeded, your insurance company will not pay; you will be responsible for payment.

c. Several insurance plans will provide coverage for your visit but all testing (strep, flu, urinalysis, etc.) is applied to your deductible and is your responsibility at the time of service.

4) It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered.

5) Newborns must be added to your insurance plan in the first 30 days of life. This is not automatic. If you fail to add your child to your plan, you are responsible for payment in full.

Initial: _____

Referrals

1) Advance notice is needed for all non-emergent (e.g. speech therapy, physical therapy, etc.) referrals, typically 3 to 5 business days.

2) It is your responsibility to know if a selected specialist participates in your plan.

3) Remember, we must approve referrals before they are issued. If your child has not been seen in our office for the specific reason for referral, we may ask that you are seen by one of our providers prior to issuing the referral.

Initial: _____

Financial Responsibility

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.

2) Co-payments are due at the time of service.

3) Self-pay patients are expected to pay for services in FULL at the time of the visit.

4) Several **co-op plans** including, but not limited to Liberty Health Share, Christian Care Ministries, and MediShare do not cover vaccines and certain testing. Additionally, unless the "household annual" has been met, the cost of the visit and any testing is your responsibility. Our staff will work to confirm that the household annual has been met at the time of your visit. If we are unable to confirm, payment will be due at the time of service.

4) If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement. Charges paid at the time of service will be discounted 30%.

5) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill.

6) Any balance outstanding longer than 90 days will be forwarded to a collection agency.

7) For scheduled (non-emergency) appointments, prior balances **must be paid** prior to the visit.

8) If you participate with a high-deductible health plan, we require a copy of the health savings account debit or credit card, or a copy of a personal credit card to remain on file. It is your responsibility to update any changes with debit or credit card.

9) We accept cash, checks, Visa, and MasterCard credit and debit.

10) A $25 fee will be charged for any checks returned for insufficient funds.

11) The accompanying parent or adult is responsible for full payment at the time of service. In case of divorce, please do not place our office in the middle of marital disputes. It is your responsibility to work out the payment of your child's medical care between the custodial and non-custodial parent.

12) We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact our billing department promptly for payment arrangements and assistance in the management of your account.

13) Should your account balance become uncollectible due to bankruptcy, we will continue to see your child on an emergency basis only for the next 30 days, giving you time to find a new source of medical care.

Initial: _____

Forms

1) There is no charge for forms completed at the time of your child's visit. This is considered part of the visit. However, should you lose your forms, there will be a $15 charge to replace them.

2) Any additional school, camp, or sports forms are subject to a $15-per-form fee. Family and Medical Leave Act forms are $25. Payment is due when the forms are requested. We require 3-day turnaround time.

Initial: _____

Transfer of Records

1) If you transfer to another provider, we will provide a copy of your immunization record and your last visit to your provider, free of charge, as a courtesy to you. We need 48 hours' notice.

2) A copy of your complete record is available for a $10 flat fee. The record will be available on a CD and can be mailed directly to your new provider. Please allow 48 hours' notice.

3) We provide records of your child for visits (including consultations from specialists) rendered here at Pediatric Health Partners only. For any previous records, you must request them directly from your previous doctor(s).

Initial: _____

Prescription Refills

1) For monthly medication refills, we require 48 hours' notice, during regular business hours. Please plan accordingly. Controlled substance prescriptions must be picked up in our office. If a prescription must be

rewritten due to loss, expiration, or failure to pick up in a timely fashion, a $15 charge will be incurred. Certain conditions for which medications are required, may also be required to have more frequent follow up with a provider.

Initial: _____

After Hours Calls

1) All calls forwarded to the provider after hours will incur a $25 charge.

Initial: _____

We must emphasize that as pediatric providers, our relationship is with you and your children, not your insurance company. While the filing of insurance claims is a courtesy that we extend our patients, all charges are strictly your responsibility from *the date services are rendered*. Therefore, it is necessary for you to know what benefits your insurance plan provides for you.

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s)_____

Responsible Party Member's Name :_____Relationship_____

Responsible Party Member's Signature: _____ Date: _____

On completion, we will provide you with a copy for your records at your request.

PHP 10/2019